STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G193	A. BUILDING _____ B. WING _____	05/03/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW 02	74 'W' ST, NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A monitoring visit was conducted on 4/29/10, 4/30/10, and 5/3/10. A random sampling of three clients was selected from a resident population of three men and two women with various disabilities. The findings of the survey were based on observations, interviews with clients and staff in the home, as well as a review of client and administrative records, including incident/investigation reports. The outcome of the survey determined that the facility was not incompliance with the Condition of Participation of Client Protections and Health Care Services, as evidenced in the report that follows.	W 000	Received 6/8/10 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Based on observation, interview and record review, the governing body failed to maintain general operating direction over the facility. [See W104] The results of these systemic practices revealed that the facility's governing body failed to adequately govern the facility in a manner to ensure client protection [See W122]; and health care services. [See W318].	W 102	As of 5/14/10 a new governing body—MarJul Homes, Inc. assumed receivership of this Westview facility.	5/14/10
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy,	W 104	See W102	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Julia B Towson — TITLE: Executive Director — (X6) DATE: 6-7-2010

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interview and record review the governing body failed to maintain general operating direction over the facility as evidenced by the deficiencies cited throughout this report and the following: The findings include: 1. The Governing body failed to establish and/or implement policies to ensure the clients' health and safety . [See W149] 3. The governing body failed to ensure preventive health services and nursing services in accordance with clients' needs. [See W322 and W331]	W 104		
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on interview and record review, the facility failed to promptly notify the client's family members/legal guardians of an injury of unknown origin and allegations of abuse [See W148]; failed to implement policies and procedures that ensured clients' health and safety [See W149]; failed to ensure that an injury of unknown origin and all allegations of abuse were reported [See W153]; failed to ensure that allegations of abuse were thoroughly investigated [See W154]; failed	W 122	The New governing body has structured training sessions to address deficiencies in terms of individuals protection.	6/10/10

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W 122	Continued From page 2 to provide evidence that clients were protected from further potential abuse while an allegation of abuse was investigated [See W155]; and failed to report the results of all investigations to the administrator or designated representative within five working days of the incident [See W156]. The effects of these systemic practices resulted in the failure of the facility to protect its clients and ensure their health and safety.	W 122		
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to promptly notify the client's family members/legal guardians of an injury of unknown origin and allegations of abuse for two of five clients residing in the facility. (Clients #1 and #2) The findings include: On 4/29/10, at approximately 5:05 p.m., interview with direct care staff revealed Clients #1 and #2 both had legal guardians that were involved in their habilitation and care. This was confirmed later in an interview with the residential manager at approximately 8:20 p.m. on the same day. Review of the facility's incident reports and corresponding investigations on 4/30/10, beginning at 6:52 p.m., and on 5/3/10, at	W 148	Will be part of structured training mentioned in W122 above. See attachment #1	

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W 148	Continued From page 3 approximately 1:40 p.m., revealed the facility failed to provide evidence that Clients #1 and #2's legal guardians and/or family members were made aware of the following incidents: - An incident/investigation report dated 2/8/10, revealed that Client #1 complained to staff that his neck was bothering him. - An incident report dated 11/8/09, and corresponding investigation report dated 11/10/09, revealed an allegation of sexual abuse. Client #1 reported to staff that another staff had put his hands down his pants. - An incident report dated 9/26/09, and corresponding investigation report, revealed an allegation of verbal/physical abuse. Client #2 came into the qualified mental retardation professional's (QMRP's) office and stated that a "counselor" told him to shut up" and pushed him off the van. - An unusual incident report dated 10/2/09, and corresponding investigation report dated 10/13/09, revealed an allegation of verbal abuse. While in court, Client #2 kept raising his hand to speak. The judge allowed him to speak, and the client stated "staff was hollering at him". At the time of the survey, the facility failed to provide evidence that the legal guardians and/or family members of Clients #1 and #3 were made aware of the aforementioned incidents.	W 148		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit	W 149	As per receivership agreement MarJul Policy has been effective since 5/14/10	5/14/10

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W 149	Continued From page 4 mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to establish and/or implement policies to ensure the health and safety of three of five clients residing in the facility. (Clients #1, #2 and #3) The findings include: 1. The facility failed to ensure the Department of Health (DOH) was notified timely of significant incidents (allegations of abuse and one injury of unknown origin) in accordance with federal regulations and state law. Cross-refer to W153. Review of the facility's incident and investigation reports on 4/30/10 and 5/3/10, revealed evidence of three incidents of abuse, and one injury of unknown origin that were documented to have occurred between 9/2009 and 2/2010. Continued review of the facility's incident reports failed to show evidence that the Department of Health (DOH) was informed the aforementioned incidents timely. Interviews with the resident manager (RM) and qualified mental retardation professional (QMRP) were conducted on 5/3/10, at 4:00 p.m., and 7:20 p.m., respectively. They both indicated that staff who witnessed, discovered or were informed of the aforementioned incidents should have immediately documented the incidents on an incident report form, before the end of the shift. The RN and the QMRP stated that DOH should have been notified of all allegations of abuse and injuries of unknown origin immediately, followed	W 149		

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W 149	Continued From page 5 by written notification within 24 hours. Review of the facility's incident management policy (IMP) on 5/3/10, at approximately 6:00 p.m., revealed that incidents were categorized into both reportable and serious reportable incidents. Allegations of abuse, neglect and injuries of unknown source were identified as serious reportable incidents. According to the policy, staff were required to "immediately call" the case manager, DOH, and the client's parent or guardian for all serious reportable incidents. Incident report forms were to be completed on "all serious reportable incidents" and the incident report was to be forwarded to the DOH within 24 hours. Review of the facility's incident report, however, revealed that the facility had not consistently notified the State agency of incidents, as required. 2. The facility failed to develop written policies for incidents of abuse, neglect, mistreatment, and for injuries of unknown origin. Cross-refer to W153. Review of the facility's incident/investigation reports on 4/30/10 and 5/3/10, revealed evidence of three incidents of abuse and one injury of unknown source. There was no documented evidence that the facility's administrator had been notified of these incidents immediately. Review of the facility's "Incident Management" policy on 5/3/10 revealed procedures for both verbal and written notifications of the client's case manager, DOH, and the client's parent or guardian. The policy, however, failed to indicate that the administrator should be notified, as specified by federal regulations.	W 149		

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W 149	Continued From page 6 3. Cross-refer to W148. The facility failed to consistently implement its written policy regarding the notification of guardians and/or family members of serious reportable incidents as evidenced below. On 4/29/10, at approximately 5:05 p.m., interview with direct care staff revealed Clients #1 and #2 both had legal guardians that were involved in their habilitation and care. This was confirmed later in an interview with the residential manager at approximately 6:20 p.m. on the same day. Review of the facility's incident reports and corresponding investigations on 4/30/10, beginning at 6:52 p.m., and on 5/3/10, at approximately 1:40 p.m., revealed the facility failed to provide evidence that Clients #1 and #2's legal guardians and/or family members of were informed of all significant incident. Review of the facility's incident management policy (IMP) on 5/3/10, at approximately 6:00 p.m., revealed that allegations of abuse, neglect and injuries of unknown source were identified as serious reportable incidents. Further review of the policy revealed staff were required to "immediately call" the case manager, DOH, and the client's parent or guardian for all serious reportable incidents. 4. Cross-Refer to W154 and W155. The facility failed to thoroughly investigate significant incidents (allegations of abuse and injuries of unknown origin) and failed to prevent further abuse while an investigation was in progress in accordance with their incident management policy.	W 149		

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W 149	Continued From page 7 The review of four unusual incidents and corresponding investigative reports on 4/30/10, beginning at 6:52 p.m., revealed one incident when staff was not removed timely from the schedule, while the investigation was in progress. Review of the incident management policy on 5/3/10, at approximately 7:00 p.m., revealed the agency will provide evidence that all alleged violations are thoroughly investigated and must prevent the potential for further abuse while the investigation is in progress. 5. Cross-Refer to W156. The facility failed to ensure required investigations of injuries of unknown origin and allegations of abuse were reviewed by the administrator within five working days in accordance with their incident management policy. The review of four unusual incidents and corresponding investigative reports on 4/30/10, beginning at 6:52 p.m., revealed results of three of the investigations had not been reported to the administrator within five working days. Review of the incident management policy on 5/3/10, at approximately 7:00 p.m., revealed the results of all investigations will be reported to the agency's incident management coordinator within four days for review and approval, and ensure that it reaches the health regulatory administration and the local developmental disability agency within five working days. It was further noted, however, that this policy did not include notification of the administrator. 6. Cross-Refer to W322. The facility failed to ensure the effective implementation of it policy on "Medication Management."	W 149		

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W 149	Continued From page 8 The review of Client #3's record revealed that the facility's medical services failed to monitor the effectiveness of a prescribed medication. The review of the facility's Medication Management policy, section IV(a), Medication Monitoring (dated 1/08) on 5/3/10, at 11:07 a.m. revealed, "All medications shall be monitored by a physician." Interview with the nursing staff and the record review on 4/30/10 and 5/3/10 revealed that the effectiveness of medications prescribed for constipation, (Constulose10 gm/15 ml syrup, 30 ml by mouth daily), as needed and Milk of Magnesia, 1 ounce by mouth as needed in the evening) had not been closely monitored by the physician.	W 149		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and review of incident reports and investigations, the facility failed to ensure that all allegations of neglect or abuse, as well as injuries of unknown origin were reported immediately to the administrator and/or the Department of Health, Health Regulation and Licensing Administration (HRLA) timely, for two of the five clients residing in the facility. (Clients #1 and #2)	W 153	See W149 Above	

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W 153	Continued From page 9 The findings include: Review of the facility's incident reports and corresponding investigative reports on 4/30/10, beginning at 6:52 p.m., revealed the following: 1. An incident report (injury of unknown origin) dated 2/8/10, revealed that Client #1 complained to staff that his neck was bothering him. The nurse was called and instructed the staff to escort the client to the emergency room via the transportation van. The client was discharged with a primary diagnosis of a "[strain] neck". Further review of the incident report, revealed that the nurse and house manager were the only staff informed of the injury of unknown origin. Interview with the QMRP on 4/30/10, at approximately 7:15 p.m., revealed that he and the administrator were both informed of Client #1's injury of unknown origin on 2/8/10. There was no documented evidence, however, that the administrator was immediately notified of Client #1's injury of unknown origin, as required. 2. An incident report dated 11/8/09, and corresponding investigation report dated 11/10/09, revealed an allegation of sexual abuse. Client #1 reported to staff that another staff had put his hands down his pants. The nurse examined the client for any signs of abuse. Further review of the incident report revealed that the administrator was not informed of this allegation until 11/10/09, two days after the allegation was made. Interview with the previous Incident Management Coordinator on 5/3/10, at approximately 12:15 p.m., acknowledged that the administrator was not notified immediately of the allegation of sexual abuse until two (2) days later.	W 153		

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W 153	Continued From page 10 3. An incident report dated 9/26/09, and corresponding investigation report, revealed an allegation of verbal/physical abuse. Client #2 came into the QMRP's office and stated that a "counselor" told him to shut up "and pushed him off the van. The nurse examined the client for any signs of abuse. Further review of the incident report revealed that the administrator was not informed of this allegation. Interview with the QMRP on 4/30/10, at approximately 7:30 p.m., acknowledged that the administrator was not notified immediately of the allegation of abuse. 4. An incident report dated 10/2/09, and corresponding investigation report dated 10/13/09, revealed an allegation of verbal abuse. While in court, Client #2 kept raising his hand to speak. The judge allowed him to speak, and the client stated "staff was hollering at him". Further review of the incident report revealed that the administrator was not informed of this allegation. Interview with the QMRP on 4/30/10, at approximately 7:45 p.m., acknowledged that the administrator was not notified immediately of the allegation of verbal abuse.	W 153		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to thoroughly investigate all injuries of unknown origin and/or incidents of abuse, for two of the five clients residing in the facility. (Clients	W 154	In addition to 153 above MarJul Homes will be required to follow all DDS/DOH policy regarding staff treatment of individuals.	

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W 154	Continued From page 11 #1 and #2) The findings include: On 4/30/10, beginning at 6:52 p.m., review of the incident reports and interview with the qualified mental retardation professional (QMRP) revealed that all injuries of unknown origin and abuse must be thoroughly investigated. On 5/3/10, at approximately 1:40 p.m., continued review of the incident/investigation reports revealed the following injury of unknown origin and abuse: 1. Cross-refer to W153.1. Review of the corresponding investigation report dated 2/15/10, revealed that on 2/8/10 Client #1 complained to staff about his neck bothering him. The nurse was called and instructed the staff to escort the client to the emergency room via the transportation van. The client was discharged with a primary diagnosis of a "strain neck". Further review of the agency's internal investigation revealed the following: a. The investigation failed to include an interview and/or a written statement from the staff that completed the incident report. b. The investigation failed to include an interview with Client #1 to ascertain how the injury may have occurred to his neck. c. The investigation failed to identify a date of follow-up up with his primary care physician, as indicated on the 2/9/10, hospital discharge instructions.	W 154		

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W 154	Continued From page 12 d. The investigation failed to document interviews and/or written statements from staff on duty at the time the incident was reported. e. The investigation failed to show other possible causes of the injury. Interview with the previous Incident Management Coordinator on 5/3/10, at approximately 1:50 p.m., acknowledged that she had not thoroughly investigated Client #1's injury of unknown origin (neck strain) to determine it's cause. 2. Cross-refer to W153.2. On 5/3/10, at approximately 2:00 p.m., review of the corresponding investigation report completed on 11/10/09, revealed that Client #1 stated that "staff" put his hands down my pants. The Residential Manager (RM), nurse, and QMRP were informed. The nurse examined the client for any signs of abuse. The police were called and he was taken to a local hospital for an examination. The investigation failed to identify the date that the client was examined by the nurse. Further review of the agency's internal investigation failed to include the following: a. An interview and/or written statement from the staff that allegedly put his hands down Client #1's pants. b. An interview and/or written statement from the shift leader to whom the allegation was initially reported. c. Failed to determine on what date the nurse	W 154		

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W 154	Continued From page 13 assessed the client for any signs of abuse. Reportedly, the nurse was notified on 11/10/10, two days later. d. Failed to include the date on which Client #1 was evaluated medically after the allegation of sexual abuse. e. Failed to include an interview with Client #1 regarding the allegation of sexual abuse. Interview with QMRP on 5/3/10, at approximately 7:00 p.m., acknowledged that the sexual abuse allegation was not thoroughly investigated. 3. On 5/3/10, at approximately 2:30 p.m., review of the corresponding investigation report completed on 10/8/09, revealed that on 10/7/09, "I [Incident Management Coordinator] was informed by a counselor that Client #2 hit Client #1 in the head with a large pencil. Client #1 had a small scratch on the middle part of his head." The RM, QMRP, and nurse were notified. The nurse assessed the wound, cleaned the area, and applied triple antibiotic ointment to the area. Client #1 did not complain of pain. He ate dinner and went to bed. Further review of the agency's internal investigation revealed the following: a. The investigation failed to include an interview and/or written statement from the staff that completed the unusual incident report. b. The investigation failed to include interviews and/or written statements from two other staff who witnessed the incident.	W 154		

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W 154	Continued From page 14 c. The investigation failed to include an interview with Clients #1 and #2 to determine why the incident had occurred. Interview with QMRP on 5/3/10, at approximately 7:10 p.m., acknowledged that the client to client abuse was not thoroughly investigated. The review of the facility's policy on investigations of incidents on 5/3/10, at approximately 2:00 p.m., revealed "Staff and others knowledgeable about the incident" should be included. At the time of the survey, there was no evidence the facility had ensured that relevant details were obtained from all individuals regarding the aforementioned allegations, to ensure thorough investigations.	W 154		
W 155	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide evidence that clients were protected from further potential abuse while an allegation of abuse was investigated, for one of the five clients residing in the facility. (Client #2) The finding includes: Cross-refer W153.3. Review of the incident reports and investigations on 4/30/10, and on 5/3/10, revealed an incident/investigation dated 9/26/09. According the investigation report, Client #2 alleged that a staff told him to "shut up" and pushed him out of the van.	W 155	See W145 Above	

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W 155	Continued From page 15 Interview with the Incident Management Coordinator (IMC) and the continued review of the investigation report on 5/3/10, at approximately 12:30 p.m., revealed that "she [IMC] received a call from the qualified mental retardation professional (QMRP) regarding an allegation of abuse that occurred on 9/26/09. The QMRP informed me [IMC] that Client #2 came into her office and stated that staff told him to shut up and pushed him out the van." Further review of the investigation report included a written statement dated 10/2/09 from the alleged staff. According to the statement, "I [staff] did not push Client #2 off the van. I never touched him. I never told Client #2 to be quiet or shut up. I had never been trained on Client #2's behavior support plan. On Sunday 9/27/09 (day after the alleged incident), Client #2 was still raving about what was wrong and cussing, and the QMRP observed this and said I [alleged staff] should go to work at the other facility." Continued interview with the IMC later that day confirmed that the alleged staff did return to work the next day (9/27/09) and completed his 3:00 p.m., to 11:00 p.m. shift. The IMC stated that staff was removed from client contact due to pending allegation of abuse. This was verified through a formal letter dated 9/28/09, that was mailed to the alleged staff's home. Although the IMC and the QMRP were informed of the incident, the alleged perpetrator was allowed to return to work the next day and complete her shift, prior to being removed from the schedule. Review of the facility's incident management policy on 5/3/10, at approximately 6:00 p.m., however, revealed employees who are alleged to	W 155		

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W 155	Continued From page 16 have committed any form of abuse or neglect will be immediately placed on administrative leave or reassigned to a position that does not allow any contact with clients, until the results of the investigation are complete. At the time of the survey, there was no evidence that the facility implemented its policy to the potential for prevent further abuse of it clients, while an investigation was being conducted.	W 155		
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure required investigations of injuries of unknown origin and allegations of abuse were reviewed by the administrator within five working days, for two of five clients residing in the facility. (Clients #1 and #2) The findings include: 1. Cross refer to W154.1. Interviews with the qualified mental retardation professional (QMRP) and review of the facility's incident reports and corresponding investigative reports were conducted on 4/30/10, beginning at 6:52 p.m., and 5/3/10, at approximately 1:40 p.m. The investigative report revealed Client #1 complained to staff that his neck was bothering him. The nurse was called and instructed the staff to escort the client to the emergency room via the	W 156	In addition to W153-W155 MarJul will follow agency protocol of incident notification. See attachment #2	

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W 156	Continued From page 17 transportation van. The client was discharged with a primary diagnosis of a "strain neck". Review of the corresponding investigative report revealed that the Incident Management Coordinator (IMC) completed the investigation. There was no written evidence that the results of the investigation were reviewed by the administrator within five days. 2. Cross refer to W154.2. On 5/3/10, at approximately 2:00 p.m., review of an unusual incident report and the corresponding investigation report completed on 11/10/09, revealed that Client #1 stated that "staff" put his hands down my pants. The Residential Manager (RM), nurse, and QMRP were informed. The nurse examined the client for any signs of abuse. The police were called and he was taken to a local hospital for an examination. Review of the corresponding investigative report revealed that the Incident Management Coordinator (IMC) completed the investigation. There was no written evidence that the results of the investigation was reviewed by the administrator within five days. 3. Cross refer to W153.4. On 5/3/10, at approximately 3:15 p.m., review of the investigation report dated 10/2/09, revealed an allegation of verbal abuse. While in court, Client #2 kept raising his hand to speak. The judge allowed him to speak, and the client stated "staff was hollering at him". Review of the corresponding investigative report revealed that the Incident Management Coordinator (IMC) completed the investigation. There was no written evidence that the results of the investigation was reviewed by the administrator until 10/13/09, eleven (11) days later.	W 156		

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W 156	Continued From page 18 [Review of the facility's policy revealed "The results of all investigations will be reported to ....'s IMC within four days for raview and approval, and ensure that it reaches the HRA and DDS Incident Management Unit within five working days". There is no mentioning of the administrator's review of the investigation outcome of whether the IMC was assigned to be his designee.	W 156		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure the Qualified Mental Retardation Professional (QMRP) coordinated, integrated, and monitorad services, for four of the five of the five clients residing in the facility. Clients #1, #2, #3, #4 and #5) The findings include: 1. The facility's QMRP failed to ensure consistent documentation of progress on the Individual Program Plan (IPP) objective for Clients #3 and #4. [See W252] 2. The facility's QMRP failed to coordinate services to ensura menus were modified as necessary to provide the prescribed diet of Client #3. [See W460] 3. The facility's QMRP failed to coordinate services to ensure quarterly drug regimen	W 159	Current QMRP will coordinate to ensure all IPP objectives are being implemented and monitored. The QMRP will coordinate with the nutritionist to ensure that all individuals are following the diet and menu as prescribed by the nutritionist. The QMRP will coordinate with the psychologist and psychiatrist and nurse to ensure that quarterly all individuals' quarterly drug regimen reviews are conducted.	6/10/10

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W 159	Continued From page 19 reviews were conducted for Clients #3, #4, and #5. [See W362]	W 159		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure consistent documentation of progress on the Individual Program Plan (IPP) objectives, for two of three clients in the sample. (Clients #3 and #4) The findings include: The facility failed to ensure that data was consistently maintained on the training objectives designed to improve behavior of Clients #3 and #4, as evidenced below: a. Observation of Client #4 on 4/29/10, at approximately 6:19 p.m., revealed she began talking to herself, as she repeatedly hit herself on the left side of her head. During this time, the client's medication objective was being implemented by the licensed practical nurse (LPN). The direct care staff who escorted the client to the medication room said, "happy face" to the client several times, and she began to calm down. Review of Client #4's behavior support plan (BSP) dated 8/17/09, on 4/30/10 at 9:24 a.m., revealed the client exhibited self-injurious behaviors (SIB),	W 252	See W159 Above.	

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W 252	Continued From page 20 which included punching herself on face or head. According to Frequency of Targeted Behavior Form, the face slapping/punching behavior should be documented. The ABC Data Collection Sheet also required that antecedents, behaviors, interventions, and responses to the intervention be documented each time staff observe the client exhibit a targeted behavior. Review of the aforementioned forms on 4/30/10 at 9:35 a.m., revealed that the face slapping observed by the surveyor on 4/29/10 during the medication administration had not been documented. At the time of the survey,there was no evidence the facility had ensured consistent data collection to facilitate accurate monitoring of Client #4's progress in her behavioral objective. b. Observation of Client #3 during the medication administration on 4/29/10 at 7:26 p.m., revealed he slapped himself repeatedly on the right side of his face, as soon as the nurse assisted him to sanitize his hands. He then got up from the chair, cursing loudly, and began "puffing and blowing". The direct care staff who escorted the client to the medication room asked the client to calm down, and continued to talk to him until 7:30 p.m. Afterwards, he appeared to be calm and accepted his medications. Interview with staff on 4/29/10 during the medication administration revealed that the behaviors exhibited by Client #3 were being addressed by his BSP. Review of Client #3's BSP dated 4/19/10, on 4/30/10 at 9:47 a.m., revealed the client exhibited challenging behaviors which included screaming, face slapping, and heavy breathing. According to	W 252		

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W 252	Continued From page 21 the Frequency of Targeted Behavior Form and the ABC Data Collection Sheet, these behaviors should be documented each time staff observes the client exhibit a targeted behavior. Review of the aforementioned forms on 4/30/10 at 9:59 a.m., revealed that of the behaviors observed during the medication administration on 4/29/10, only the heavy breathing (puffing and blowing), was documented on the Targeted Behavior Form . There was no documentation on the ABC Data Collection Sheet concerning the observed targeted behavior. At the time of the survey, there was no evidence the facility had ensured consistent data collection to facilitate accurate monitoring of Client #3's progress in his behavioral objective.	W 252		
W 318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on interviews, and record verification, the facility failed to ensure timely preventive health services were coordinated [Refer to W322]; the facility's nursing services failed to establish systems to provide health care monitoring and identify services in accordance with clients' needs [Refer to W331]; and the facility failed to ensure therapeutic diets were provided as prescribed [Refer to W460]. The results of these systemic practices results in the demonstrated failure of the facility to provide health care services.	W 318	Under the new nursing team all nursing services will be delivered based on MarJul Homes Policy and procedure. See attachment #3	6/10/10
W 322	483.460(a)(3) PHYSICIAN SERVICES	W 322		

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W 322	Continued From page 22 The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure timely preventive health services for one of three clients in the sample. (Client #3) The findings include: 1. [Cross refer to W331]. The facility failed to ensure timely medical follow-up for Client #3 with the primary care physician (PCP) after his emergency room visits due to constipation. Record review on 4/30/10 at 6:35 p.m. revealed that Client #3 had several hospitalizations for intestinal obstruction and a total colostomy for a volvulus in April 2008. Although the colostomy was reversed in November 2008, he continued to have GI problems as evidenced below: a. On 4/30/10, at 10:37 a.m., the review of an unusual incident report (UIR) dated 4/5/10, revealed that at 9:15 p.m., a direct care staff (DCS) discovered Client # 3 on the floor and crying. He was taken to the emergency room (ER) for evaluation and was diagnosed with "pain -abdominal" and "constipation -slow transit". The client returned to the emergency room on 4/6/10 for assessment of vomiting. Review of the ER discharge summary dated 4/6/10, for the 4/5/10 visit revealed "follow up with the PCP in two to four days" and to "contact the ER," if there was a problem arranging the follow visit with the PCP. A	W 322	See W318	

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W 322	Continued From page 23 high fiber diet and more fluids were recommended. Record review on 4/30/10, at approximately 6:10 p.m., revealed a consultation report from the PCP dated 4/13/10, which stated that the client was evaluated in the ER for constipation and that the symptoms were now resolved. The PCP, however, made no specific recommendations on how to monitor the problem. Additionally, there was no evidence that the client receive follow-up within the recommended time frame. [Note: Client #3's stool records revealed he continued to have hard stools.] every one to three days, between 4/13/10 and 4/24/10. Documentation of stools between 4/24/10 and 4/30/10, revealed no evidence that the client had any stools for six days. Due to a complaint of abdominal pain, the client returned to the ER on 4/30/10 and was diagnosed with constipation. b. The review of an UIR dated 12/8/09 at 8:30 p.m. revealed Client #3 was evaluated at the ER on 12/8/09 for constipation. Review of Clients #3's 12/9/09 ER discharge instructions revealed a primary diagnosis of pain-abdominal, generalized and a secondary diagnosis of Constipation - unspecified. The discharge summary included a recommendation for follow-up by the primary care physician (PCP) in 1 - 2 days, without fail. The client record failed to document evidence that the PCP follow-up until 12/14/09, five days after his readmission to the group home. 2. The facility's primary care physician (PCP) failed to ensure oversight of the medication and diet prescribed for Client #3 to prevent constipation as evidenced below:	W 322		

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W 322	Continued From page 24 During the medication administration observations on 4/29/10, at 7:28 p.m., Client #3 received Docusate sodium 50 mg/5 ml, 100 mg/10 ml by mouth. The review of the 4/1/10 physician's orders revealed the medication was prescribed as a stool softener at 6:00 p.m. daily. Further record review on 5/3/10 at 10:45 a.m., revealed a current physician's order for Constulose 10 gm/15 ml syrup, 30 ml by mouth daily, as needed for constipation. The physician's orders revealed that the Constulose was initially prescribed on 10/23/09 by the gastroenterologist and was subsequently approved by the PCP. Review of the medication administration for 10/2009 revealed a 10/23/2009 order for "Lactulose 30 ml po daily as need for constipation." On 5/3/10 at approximately 7:45 p.m., interview with the newly hired registered nurse (RN) revealed that it could not be ascertained if and when the client may have received the Constulose other than in 12/09. Continued interview with the RN and the licensed practical nurse (LPN) revealed that no Constulose available at the facility. On 5/3/10 at 10:35 a.m., the review of the medication administration record (MAR) for 11/09 revealed that MOM 1 oz. PO as needed in the evening was listed and not the Constulose. According to the 12/2009 MAR, the client was administered Constulose in the evening on eleven days. Continued review of the MARs from 10/2009 through 5/3/10, however, revealed no documentation that Client #3 was administered Constulose at any other time. It should be noted that the MAR documented the administration of	W 322		

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W 322	Continued From page 25 MOM on 10/11/09 (for hard stool) and 10/14/09 (for no stool reported by staff). At the time of the survey, there was evidence medical criteria had been established to determine when to administer the Constulose and/or the prn. Additionally, there was no evidence effective preventive measures had been implemented to minimize Client #3's risk of constipation. [See also W460] 3. The facility's medical services failed to ensure timely treatment for Client #3 to address his dental caries. [See W356]	W 322		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure nursing services were provided in accordance with the needs of four of five clients residing in the facility. (Clients #2, #3, #4, and #5) The findings include: 1. The facility's nursing services failed to ensure close monitoring and implementation of measures to minimize the frequency of Client #3's emergency room (ER) visits due to constipation, as evidenced below: Interview with the residential staff on 4/30/10, at 8:49 a.m., revealed Client #3 had been hospitalized several times since the 6/25/09 survey. Interview with the home manager on 4/30/10, at approximately 9:40 am. , revealed the	W 331	MarJul Homes will follow nursing protocol for individuals; to include medications administered every other day as needed.	6/10/10

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W 331	Continued From page 26 practice was if the client did not have a bowel movement within 2 to 3 days, the nurse was informed, so that the client received his pm medication for constipation. The home manager also indicated that that if the client did not have a stool in 3 to 4 day, upon assessment by the nurse and instructions by the physician, the client was to be taken to the emergency room (ER) for assessment. Interview with the recently hired registered nurse (RN) on 5/3/10 at approximately 7:40 p.m., however revealed that she had not seen a written policy stating when the client should be taken to ER for constipation. It should be noted, however, that Client #3's stool records revealed he continued to have hard stool every one to three days, between 4/13/10 and 4/24/10. Documentation of stools between 4/24/10 and 4/30/10, revealed no evidence that the client had any stools for six days. Due to a complaint of abdominal pain, the client returned to the ER on 4/30/10 and was diagnosed with constipation. Additional record review on 4/30/10 and on 5/3/10 confirmed the following ER visits/ hospitalization had occurred for Client #3: a. A "Further Evaluation /Services Request (FER)" from Client #3's day program dated 9/14/09 (12:30 p.m.) revealed he was evaluated for his complaint of abdominal pain, holding his abdomen tight and crying. Upon assessment the client's abdomen appeared very hard and distended. The client was reported as oriented x 3, to have faint bowel sounds, BP 156/96, T97 ,P76 R28. He appeared to be constipated - sat on the commode for a while, pushed and groaned, but could not go. Please treat	W 331		

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W 331	Continued From page 27 accordingly and monitor closely. On 9/14/10, at 6:45 p.m., the RN wrote a reply at the bottom of Client #3's aforementioned FER from his day program. The note revealed, "Antacid given with relief. Laxative given 3 hours later. Fluids pushed. Vital signs were normal....Abdomen distended without complaint of pain during assessment. Ongoing assessment by staff. (Note: Review of the medication administration record (MAR) revealed the RN administered antacid suspension, 1 tablespoon (prescribed every four hours as needed for abdominal distress) at 3:20 p.m. and that the result was effective. The MAR also documented that Milk of Magnesia (MOM), 1 ounce (prescribed to be given every evening as needed for constipation) was given at 6:00 p.m. and there was no result). Review of an unusual incident report (UIR) dated 9/14/09 revealed at approximately 8:45 p.m., Client #3 was observed holding his stomach and complaining of pain. The supervisor was notified, and upon notification and instructions by the RN., the client was escorted to the hospital ER for evaluation. A CT scan of the abdomen confirmed a small bowel obstruction. The medical impression was that it was most likely related to adhesions. The final diagnosis was "Small bowel obstruction, now resolved with conservative therapy." A low residue discharge diet was prescribed. The client was discharged back to his group home on 9/24/09 b. The review of an UIR dated 12/8/09 on 4/30/10 at 8:30 p.m. revealed that on 12/7/09, a direct	W 331		

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W 331	Continued From page 28 care staff (DCS) informed the nurse that Client #3 had not had a bowel movement since 12/4/09. On the next day (12/8/09) at approximately at 4:00 p.m., the LPN contacted the staff and stated that per the RN coordinator's instructions, the client should be taken to the ER, if he did not have a BM. Upon review of the client's record, it was was determined by the LPN an the Quallfied Mental Retardation Professional (QMRP) that the client should be taken to the ER for evaluation. On 4/30/10 at approximately 7:10 p.m., review of Client #3's 12/9/09 ER discharge instructions revealed a primary diagnosis of pain-abdominal, generalized and a secondary diagnosis of Constipation - unspecified. Blood work, and an acute abdomen series and a CT of abdomen and pelvis w/ contrast were performed stat due to the client's complaint of abdominal pain. The client was discharged from the ER in satisfactory condition with a recommendation for follow-up by the primary care physician (PCP) in 1 - 2 days, without fail. c. On 4/30/10 at 10:37 a.m., the review of an unusual incident report (UIR) dated 4/5/10 revealed that at 9:15 p.m. a direct care staff (DCS) discovered Client #3 on the floor holding his side crying, and saying "I need to go to the hospital". According to the UIR, the supervisor was informed of the client's complaint, then telephoned the registered nurse. Further review of the UIR revealed the R.N. instructed staff to escort the client to the hospital. The client was diagnosed with and treated for constipation, and then released to the group home. (Note: An RN progress noted dated 3/21/10 documented "poor water intake, B/M reportedly remain irregular. Will continue to monitor." The next RN entry, dated	W 331		

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W 331	Continued From page 29 4/3/10 reported "regular coaxing to drink water, no medical sign of issue reported." d. On 4/30/10, at 4:45 p.m., the review of an UIR dated 4/6/10 revealed that at 10:30 p.m., a direct care staff observed Client #3 standing at the main entrance of the facility. The UIR documented that the client had vomited all over the area. The R.N. was notified immediately and instructed staff to take the client back to the emergency room for further evaluation. e. On 4/30/10, at 10:35 a.m., very loud yelling was heard coming from the front of the facility. The home manager went to check, and returned saying that Client #3, was the individual yelling. The manager commented that something was wrong with him. Upon attempting to determine the reason for the client's yelling, the home manager discovered that the client complained of stomach pain and said that he wanted to go to the hospital. By 10:42 a.m., the yelling had subsided, however, the client continued to whine. At 10:45 a.m., the home manager was observed preparing to send the client to the ER with a DCS. Record review on 5/3/10, at 10:40 a.m., revealed Client #3 was discharged from the ER on 5/1/09 and that his primary diagnosis was constipation. 2. Cross Refer to W322.2. The facility's nursing staff failed to coordinate services with the primary care physician and the gastroenterologist to determine the criteria for administering the prn medication to prevent Client #3's constipation as evidenced below: Interview with staff from the day, evening, and overnight shifts at various times on 4/30/10 and	W 331		

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W 331	Continued From page 30 5/3/10 revealed Client #3 continued to difficulty with regular bowel movements. The staff indicated that they had been instructed to inform the nurse if the client did not have a BM in two to three days. The staff also reported that the client's stools were often large and hard stools. Review of the daily stool documentation on 5/3/10 at approximately 11:35 a.m., for the 4/2010 confirmed the staff statements. Interview with the recently hired RN on 5/3/10 at approximately 7:40 p.m., however revealed she was hired by the agency on 4/8/10. The RN acknowledged that there had been several changes in the RN coverage at the facility. The RN revealed that her review of Client #3's record failed to identify instructions or a protocol on when the client was to be given the prn medications (Constulose or Milk of Magnesia) for constipation. On 4/30/10 at 6:40 p.m., review of an RN progress note dated 10/22/09 written to the gastroenterologist (GI) revealed, " He was last hospitalized on 9/14/09 for bowel obstruction. He has had problems with regular bowel movements. His diet was changed from high fiber to low residue. The docusate sodium does not appear to keep him regular. Is there another medication he can take? Fluid intake is good. Hospitalized for GI Distress 6/7/09 and 9/14/09. The GI responded by prescribing Lactulose 30 ml po prn constipation prn and to follow up in 2 months." On 4/30/10, at 6:55 p.m., review of a RN monthly progress summary dated 11/09 (for 10/09), indicated that the GI specialist had added a prn laxative to Client #3's medication regimen. The staff are continually reeducated verbally regarding the need to follow closely. [The client's]	W 331		

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W 331	Continued From page 31 elimination pattern still erratic (every 3 days or 4 days), taking medications as directed. The nurse acknowledged the GI's order for Lactulose pm to assist in his GI issues.. and noted "Bowel movements noted every 3 - 4 days. Drs.. are aware." Continued record review on 5/3/10, at 11:07 a.m., revealed the monthly nursing summaries for 1/09 and 12/09 documented an erratic stool pattern, with Client #3 having stools every three to four days. It should be noted that although nursing progress notes dated 1/18/10, documented that Client #3 should receive the Constulose 30 ml daily pm, review of the medication administration records revealed that the client had only received it during 12/09. At the time of the survey, there was no evidence nursing services had coordinated with the primary care physician and the gastroenterologist to obtain further instructions on when to administer the pm medication for constipation. [Note: Observation of the medication supply on 4/29/10 at 7:40 p.m. and again on 7:50 p.m., revealed no Constulose was available at the facility.] 3. The facility's nursing staff failed to accurately communicate Client #3 medication prescribed for constipation on the consultation referral form to the when Client #3 was taken to the emergency room for constipation on 12/8/09 as evidenced below: Review of a medical consultation form dated	W 331		

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W 331	Continued From page 32 12/7/09 which was written by the RN coordinator revealed the purpose of the consult as "No BM for 3-4 days, decreased bowel sounds. Treatment Lactulose BID and Docusate BID." The review of the physicians order as the time the consult was written revealed that Client #3 was prescribed Docusate 100 mg at 6:00 p.m. daily only and that that the Lactulose/Constulose, was prescribe prn. Further record review revealed no evidence that the client prescribed or had received Docusate or Lactulose twice daily. 4. The facility failed to ensure lost/missing medication was documented as evidenced below: Observation of the medication administration on 4/29/10 at 7:35 p.m., revealed that Client #2 received Dilantin 50 mg tab (3 tabs), 150 mgs. The nurse was observed to punch the pills from the section of the card dated 4/30/10. Interview with the nurse at the time the medication was punched from the card for Client #2 revealed he did not know the reason the evening dosage of the Dilantin for 4/29/10 was missing. Further interview with the both the R.N. and the medication nurse on 4/29/10 indicated that a dosage of the Dilantin was already missing from the card when they began working for the agency, approximately 10 days prior to the survey. According to the nurses, if a client's medication was lost for any reason, it should be documented in the client's record, then reordered from the pharmacy. 5. [Cross Reference W336] The facility's nursing staff failed to ensure quarterly medical assessments were completed in a timely manner.	W 331		

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W 331	Continued From page 33 The quarterly nursing assessments were not conducted timely for Clients #3,#4, and #5. Interview with the facility's Registered Nurse on 4/29/2010 at approximately 4:51 p.m. confirmed the facility's nursing oversight and services were inconsistent and that some assessments were unavailable for review. She further indicated she was newly hired on 4/8/2010 and was working diligently to correct the problems with the nursing services. 6. [Cross Reference to W362] The facility's nursing services failed to coordinate with the pharmacist to ensure that quarterly drug regimen reviews were conducted for Clients #3, #4, and #5.	W 331		
W 336	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility's nursing services failed to ensure consistent implementation of quarterly reviews for three of three sampled clients. [Clients #3, #4, and #5] The findings include: Record review on 4/30/2010, at 6:35 p.m., revealed the most recent nursing quarterly on file for Client #3 was signed and dated 12/2009. On 4/30/2010, at 1:42 p.m. and 2:08 p.m.	W 336	All nursing services will be completed in a timely manner including follow-up of all consultants recommendations as well as timely completion of all nursing quarterly assessments and nursing monthly notes.	6/10/10

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W 336	Continued From page 34 respectively, record review revealed the most recent nursing quarterlies on file for Clients #4 and #5 were signed and dated 9/2009. Interview with the facility's registered nurse (RN) on the same day at approximately 2:50 p.m., confirmed there were no quarterly assessments completed after 9/2009 for Clients #4 and #5. Continued Interview with the RN on 4/30/2010, at approximately 7:15 p.m., confirmed no quarterly assessment was completed for Client #3 after 12/2009. At the time of the survey, the facility failed to ensure the timely completion of nursing quarterly assessments to ensure the health and safety of Clients #3, #4, and #5.	W 336		
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure timely treatment services for the maintenance of dental health of one of three clients in the sample. (Client #3) The finding includes: Observation of Client #3 on 4/29/10, at 7:22 p.m., revealed he had missing teeth.	W 356	The nursing staff will follow all dental policy and procedure to deliver timely services to the individuals. See attachment #5	

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W 356	Continued From page 35 Interview with direct care staff on 5/3/10, at approximately 3:35 p.m. revealed Client #3 required encouragement and assistance from staff to ensure thorough tooth brushing. Record review on 5/3/10, at 4:07 p.m., revealed the following information regarding Client #3's dental health during consultations: (a) 10/1/09 - The periodontist diagnosed the client with severe gingivitis, heavy plaque and calculus, and generalized caries of teeth #'s 4,12, and 15. Full mouth scaling was performed, however, the periodontist recommended that the caries be addressed by a general dentist. (b) 11/23/09 - The general dentist conducted Client #3's annual oral examination and diagnosed large deposits of plaque and calculus on most teeth surfaces. At that time, however, there was no mentioning of any dental caries. (c) 2/3/10 - The periodontist again noted, "Generalized caries to be addressed by general dentist". (d) 4/7/10 - The periodontist documented, "Needs appointment with general dentist for caries control". At the time of the survey, there was no evidence that the Client #3's caries identified by the periodontist on 10/1/09 had been addressed.	W 356		
W 362	483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly.	W 362	MarJul Homes contracted pharmacist will review all individuals drug regimen each quarter.	

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W 362	Continued From page 36 This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure consistent quarterly drug regimen reviews for three of the three clients in the sample. [Client #3, #4, and #5] The findings include: Observation of the medication administration on 4/29/10, at 6:19 p.m., revealed Client #4 was administered Risperdal 3 mg and Geodon 20 mg. On the same date at 7:22 p.m., Client #3 was administered Lipitor 20 mg and Docusate Sodium 50 mg/5 ml, 10 mls . At 6:35 p.m.,on that evening ,Client #5 was administered Tegretol 200 mg and Risperdal 0.5 mg by mouth. Record review on 4/30/10, at 2:35 p.m., 2:45 p.m., and 2:05 p.m. respectively, revealed the most recent drug regimen reviews on file for Clients #4, #3, and #5 was signed and dated 1/6/10. Interview with the facility's Registered Nurse (RN) on the same day at 2:45 p.m. confirmed there was no other drug regimen review on file for Clients #3, #4, and #5. At the time of the survey, there was no evidence the facility had ensured that drug regimen reviews had been conducted at least quarterly, as required.	W 362		
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.	W 460		

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W 460	Continued From page 37 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the therapeutic diet was provided as prescribed for one of three in the sample. (Client #3) The finding includes: 1. The primary care physician (PCP) and the facility nutritionist failed to ensure timely monitoring of Client #3's constipation, as evidenced below: (a) On 4/30/10 at 8:30 p.m. , the review of an (UIR) dated 9/14/09, revealed at approximately 8:45 p.m.,Client #3 was admitted to the hospital with a diagnosis of small bowel obstruction. A low residue diet was prescribed at discharge and the client was readmitted to his group home on 9/24/09. A registered nurse (RN) coordinator progress note dated 4/5/2010, documented the client would receive follow-up by the PCP and the nutritionist. Continued record review on 5/3/10 at approximately 4:00 p.m. revealed a "readmission nutrition report" dated 10/12/09, two weeks after Client #3's return to the home. The report acknowledged the client's hospital diagnosis of constipation and recommended to discontinue previous diet and to provide a low residue diet with Ensure twice daily. It also noted that 8 glasses of water daily should be encouraged and recommended that a physical therapy consult be conducted for a possible exercise program. There was no evidence, however, that the nutritional assessment had been conducted timely or	W 460	MarJul Homes will follow through on all nutritional concerns via the agency's nutrition policy. See attachment #6	

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W 460	Continued From page 38 assessed the feasibility of using foods to improve the client's irregular bowel elimination. (b) The review of an unusual incident report (UIR) dated 12/8/09 on 4/30/10, at 8:30 p.m., revealed Client #3 was taken to the emergency room (ER) for an evaluation due to no bowel movements for several days. The 12/9/09 ER discharge instructions revealed a primary diagnosis of pain-abdominal, generalized and a secondary diagnosis of Constipation - unspecified. The aftercare instruction suggested not enough roughage or fiber and liquids in the diet as a possible cause of the constipation. Recommendations included a high fiber diet and 10 -12 cups of fluids daily. On 5/3/10, at approximately 4:10 p.m., review of the Annual Nutrition Note, dated 12/29/09 revealed the post hospital nutrition follow-up was not conducted until three weeks later. This assessment documented that the client would benefit from a high fiber diet. It further included a recommendation to discontinue the low residue diet, implement a high fiber diet, and to "encourage fluids daily". No specific instructions, however, were included on how much fluids to give daily. There was no evidence there the PCP had coordinated with nutritionist to ensure that the client's constipation was addressed timely and effectively. 2. The facility failed to ensure that menus were adjusted to accommodate the high fiber diet, mechanical soft recommended for Client #3, as evidenced below: On 4/30/10, at 10:37 a.m., the review of an UIR dated 4/5/10, at 9:15 p.m., revealed Client #3 was	W 460		

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W 460	Continued From page 39 taken to the ER where he was diagnosed with, and treated for constipation. Continued review of the UIRs revealed on 4/6/10, at 10:30 p.m., the client returned to the ER due to vomiting. On 5/3/10 at approximately 4:25 p.m., the review of the "nutrition assessment quarterly note" dated 4/13/10 revealed, "Individual continues to suffer from constipation. Diet appropriate to overall health. blood urea nitrogen (BUN) slightly high. possible hydration issue. Will encourage fluids daily." At that time, a high fiber diet with prune juice twice daily was recommended. No specific instructions, however, were included on how much fluids to give daily. Continued record review on the same day at approximately 4:35 p.m. revealed Client #3's "follow-up nutrition assessment" was dated 4/29/10. According to the assessment, the client was "having difficulty swallowing regular consistency. Individual holds food in mouth, takes a very long time swallowing. Individual will be able to tolerate a mechanical soft diet. Will notify SLP (speech and language) for screening." At the time of the survey. however, the SLP screening had not been scheduled. Review of the menus on 4/30/10 at 9:30 a.m. revealed a single menu for all clients. Interview with the nutritionist on 4/30/10 at 10:39 a.m. revealed that the menus were "Heart Healthy" and should be appropriate for all clients in the facility. Interview with staff on 5/3/10, at 4:40 p.m., revealed that the client's food was cut to bite size and that he could chew it finely, but it took him a long time. On 5/3/10 at 5:05 p.m., review of menus available	W 460		

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W 460	Continued From page 40 at the group home for 4/2010 and 5/2010 revealed they failed to provide specific guidelines for staff on how to prepare a mechanically soft high fiber diet. For example, a note on the 5/2010 menu for Client #3 stated only "high fiber, mechanical soft - extra fruits/vegetables, chopped meats." 3 returned to the ER on 4/30/10. The discharge summary dated 5/1/10, revealed that he was again diagnosed with constipation.]	W 460		

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R 000	INITIAL COMMENTS A monitoring visit was conducted on 4/29/10, 4/30/10, and 5/3/10. A random sampling of three residents was selected from a resident population of three men and two females with various disabilities. The findings of the survey were based on observations, interviews with residents and staff in the home, as well as a review of resident and administrative records, including incident reports. The outcome of the survey determined that the facility was not compliance with 22 DC Municipal Regulations, Chapter 3500, Group Homes for the Mentally Retarded, as evidenced in the report that follows.	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure all criminal background checks covered where the employee worked or lived over the past seven (7) years as required by this section. [Staff #2 and #3] The finding includes: Interview with the facility's House Manager (HM) on 4/29/10 at approximately 12:10 p.m. revealed the facility has hired four new staff since 12/2009.	R 125	The governing body will ensure that all staff have provided the agency with their background checks for all jurisdictions where they have either worked or lived in the past seven years.	

Julia B Towson — Executive Director
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 6-7-2010

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R 125	Continued From page 1 Of the four newly hired staff, two of the criminal background checks failed to reflect a search was conducted in all areas where they either worked or lived over the past seven years as evidenced below: 1. Record review on 4/29/10, at approximately 12:20 p.m., revealed, Staff #2 ' s job application listed him as either having worked or lived in the states of West Virginia and Pennsylvania within the past seven years. The criminal background check on record at the time of survey only covered the surrounding states of Maryland, Virginia and the District of Columbia. 2. Record review on 4/29/10, at approximately 12:25 p.m., revealed, Staff #2 ' s job application listed him as either having worked or lived in the state of Florida within the past seven years. The criminal background check on record at the time of survey only covered the District of Columbia. Further interview with the facility's HM on the same day at approximately 2:25 p.m. revealed, she was not sure if the qualified mental retardation professional (QMRP) for the home had additional " new hire " information on these staff to address this oversight. There was no evidence on file at the time of survey to substantiate that all criminal background checks were conducted to cover the seven year requirement as cited above.	R 125		

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I 000	INITIAL COMMENTS A monitoring visit was conducted on 4/2910, 4/30/10, and 5/3/10. A random sampling of three residents was selected from a resident population of three men and two women with various disabilities. The findings of the survey were based on observations, interviews with residents and staff in the home, as well as a review of resident and administrative records, including incident reports. The outcome of the survey determined that the facility was not compliance with 22 DC Municipal Regulations, Chapter 3500, Group Homes for the Mentally Retarded, as evidenced in the report that follows.	I 000		
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the GHMRP failed to ensure that the qualified mental retardation professional (QMRP) coordinated, integrated and monitored services for three of the five residents residing in the facility. Residsents #3, #4 and #5) The findings include: The findings include: 1. The facility's QMRP failed to ensure consistent documentation of progress on the Individual Program Plan (IPP) objective for Residents #3 and #4. [See W252]	I 180	See W252 and W159	

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I 180	Continued From page 1 2. The facility's QMRP failed to coordinate services to ensure menus were modified as necessary to provide the prescribed diet of Resident #3. [See W460] 3. The facility's QMRP failed to coordinate services to ensure quarterly drug regimen reviews were conducted for Residents #3, #4, and #5. [See W362]	I 180		
I 204	3509.4 PERSONNEL POLICIES Each employee shall be given a copy of his or her job description to review and sign at the beginning of employment. This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for the Mentally Retarded Person(s) (GHMRP) failed to ensure all staff was provided a job description to review and sign at the start of employment for four of four newly hired staff. [Staffs #1, #2, #3, and #4] The finding includes: Interview with the facility ' s House Manager (HM) on 4/29/10, at approximately 12:10 p.m., revealed the facility has hired four new staff since 12/2009. Record review on the same day at approximately 1:15 p.m. revealed, none of the four staff records reviewed showed evidence of a signed (valid) job description. The GHMRP failed to ensure all staff was provided a copy of their job description to sign and review prior to employment as required by this section.	I 204	The Human Resources Department at MarJul Homes will ensure that policy and procedures with regards to personnel records and staff training will be followed.	

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I 207	Continued From page 2	I 207		
I 207	3509.7 PERSONNEL POLICIES A new employee ' s physical examination shall have been performed within ninety (90) days prior to employment. This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for the Mentally Retarded Person(s) (GHMRP) failed to ensure all staff completed a physical examination at least ninety (90) days prior to their start of employment. [Staff #1, #2, #3, and #4] The finding includes: Interview with the facility ' s House Manager (HM) on 4/29/10, at approximately 12:10 p.m., revealed the facility has hired four new staff since 12/2009. Record review on the same day at approximately 12:45 p.m. revealed, none of the four staff records reviewed showed evidence of a physical examination. Further interview with the facility ' s House Manager (HM) on 4/29/10 at approximately 1:05 p.m. revealed the additional personnel records may be with the Qualified Mental Retardation Professional (QMRP) because what she presented to the survey team was all that was on file at the time. The GHMRP failed to ensure all staff completed a physical examination prior to employment as required by this section.	I 207	See I204	
I 221	3510.2 STAFF TRAINING	I 221		

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I 221	Continued From page 3 Orientation training shall be the responsibility of each GHMRP and shall be documented in each employee ' s personnel folder. This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for the Mentally Retarded Person(s) (GHMRP) failed to provide orientation training for four of the four newly hired staff. [Staff #1, #2, #3, and #4] The finding includes: Interview with the facility ' s House Manager (HM) on 4/29/10, at approximately 12:10 p.m., revealed the facility has hired four new staff since 12/2009. Record review on the same day at approximately 12:30 p.m. revealed, none of the four staff records reviewed showed evidence of orientation training. Further interview with the facility ' s HM on the same day at approximately 1:00 p.m. revealed, she was not sure if the training records for the new staff was being kept at the main office. There was no evidence on file at the time of survey to substantiate that all new staff received orientation training as required by this section.	I 221	See I204	
I 223	3510.4 STAFF TRAINING Each training program agenda and record of staff participation shall be maintained in the GHMRP and available for review by regulatory agencies. This Statute is not met as evidenced by: Based on staff interview, the Group Home for the Mentally Retarded Person(s) (GHMRP) failed to	I 223	See I204	

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I 223	Continued From page 4 ensure all training records were made available at the time of survey. The finding includes: [Cross Reference 3510.2] Interview with the facility ' s House Manager (HM) on 4/29/10, at approximately 1:00 p.m., verified all the training records for the four newly hired staff were not available for review. She further indicated that the additional training sheets may be with the Qualified Mental Retardation Professional (QMRP) because what she presented to the survey team was all that was on file at the time. The GHMRP failed to provide all training agenda and record of staff participation to the survey team as required by this section.	I 223		
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans; This Statute is not met as evidenced by: Based on record review and staff interview, the Group Home for the Mentally Retarded Person(s) (GHMRP) failed to ensure all staff completed training in performing first aid and CPR. [Staff #1, #2, #3, and #4] The finding includes:	I 227	See I204	

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I 227	Continued From page 5 Interview with the facility ' s House Manager (HM) on 4/29/10, at approximately 12:10 p.m., revealed the facility has hired four new staff since 12/2009. Record review on the same day at approximately 12:55 p.m. revealed, none of the four staff records reviewed showed evidence of either first aid or CPR training. The GHMRP failed to ensure all staff received training in the areas of implementing First Aid or CPR as required by this section.	I 227		
I 374	3519.5 EMERGENCIES After medical services have been secured, each GHMRP shall promptly notify the resident ' s guardian, his or her next of kin if the resident has no guardian, or the representative of the sponsoring agency of the resident ' s status as soon as possible, followed by written notice and documentation no later than forty-eight (48) hours after the incident. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to promptly notify the resident's guardian, his or her next of kin after medical services were secured, followed by written notice and documentation no later than 48 hours after the incident, for two of five residents in the GHMRP. (Residents #1 and #2) The findings include: On 4/29/10, at approximately 5:05 p.m., interview with direct care staff revealed Residents #1 and #2 both had legal guardians that were involved in their habilitation and care.	I 374	See W156	

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I 374	Continued From page 6 Review of the GHMRP's incident reports and corresponding investigations on 4/30/10, beginning at 6:52 p.m., and on 5/3/10, at approximately 1:40 p.m., revealed the GHMRP failed to provide evidence that legal guardians and/or involved family members of Residents #1 and #2 were made aware of the following incidents: 1. An incident/investigation report (injury of unknown origin) dated 2/8/10, revealed that Resident #1 complained to staff that his neck was bothering him. 2. An incident report dated 11/8/09, and corresponding investigation report dated 11/10/09, revealed an allegation of sexual abuse. Resident #1 reported to staff that another staff had put his hands down his pants. 3. An incident report dated 9/26/09, and corresponding investigation report, revealed an allegation of verbal/physical abuse. Resident #2 came into the qualified mental retardation professional's (QMRP's) office and stated that a "counselor" told him to shut up" and pushed him off the van. 4. An unusual incident report dated 10/2/09, and corresponding investigation report dated 10/13/09, revealed an allegation of verbal abuse. While in court, Resident #2 kept raising his hand to speak. The judge allowed him to speak, and the resident stated "staff was hollering at him". At the time of the survey, the GHMRP failed to provide evidence that the legal guardians and/or involved family members of Residents #1 and #2 were made aware of the aforementioned	I 374		

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I 374	Continued From page 7 incidents.	I 374		
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and review of incident reports and investigations, the group home for the mentally retarded persons (GHMRP) failed to notify the Department of Health, Health Regulation and Licensing Administration (HRLA) of unusual incidents or events which substantially interferred with the resident's health, welfare, living arrangements, well-being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day for two of the five residents in the GHMRP (Resident's #1 and #2) The findings include: Review of the GHMRP's incident reports and corresponding investigative reports on 4/30/10, beginning at 6:52 p.m., revealed the following: 1. An incident report (injury of unknown origin)	I 379	See W156	

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I 379	Continued From page 8 dated 2/8/10, revealed that Resident #1 complained to staff that his neck was bothering him. The nurse was called and instructed the staff to escort the resident to the emergency room via the transportation van. The resident was discharged with a primary diagnosis of a "[strain] neck". Further review of the incident report, under the section of "verification notification", revealed that the nurse and house manager were the only staff informed of the injury of unknown origin. Interview with the QMRP on 4/30/10, at approximately 7:15 p.m., revealed that he and the administrator were both informed of Resident #1's injury of unknown origin on 2/8/10. However, there was no documented evidence that the administrator was immediately notified of Resident #1's injury of unknown origin. 2. An incident report dated 11/8/09, and corresponding investigation report dated 11/10/09, revealed an allegation of sexual abuse. Resident #1 reported to staff that another staff had put his hands down his pants. The nurse examined the resident for any signs of abuse. Further review of the incident report revealed that the administrator was not informed of this allegation until 11/10/09, two days after the allegation was made. Interview with the previous Incident Management Coordinator on 5/3/10, at approximately 12:15 p.m., acknowledged that the administrator was not notified immediately of the allegation of sexual abuse until two (2) days later. 3. An incident report dated 9/26/09, and corresponding investigation report, revealed an allegation of verbal/physical abuse. Resident #2 came into the QMRP's office and stated that a "counselor" told him to shut up "and pushed him	I 379		

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I 379	Continued From page 9 off the van. The nurse examined the resident for any signs of abuse. Further review of the incident report revealed that the administrator was not informed of this allegation. Interview with the QMRP on 4/30/10, at approximately 7:30 p.m., acknowledged that the administrator was not notified immediately of the allegation of abuse. 4. An incident report dated 10/2/09, and corresponding investigation report dated 10/13/09, revealed an allegation of verbal abuse. While in court, Resident #2 kept raising his hand to speak. The judge allowed him to speak, and the resident stated "staff was hollering at him". Further review of the incident report revealed that the administrator was not informed of this allegation. Interview with the QMRP on 4/30/10, at approximately 7:45 p.m., acknowledged that the administrator was not notified immediately of the allegation of verbal abuse.	I 379		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview, and record review, the GHMRP failed to ensure professional services included timely diagnostic, evaluation, and treatment services to prevent deterioration or further loss of functioning for four of five residents. (Residents #1, #3, #4, and 5)	I 401	See W318 and W156	

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I 401	Continued From page 10	I 401		

The findings include:

I. The GHMRP's nursing services failed to ensure services were provided in accordance with the needs of Residents #1, #2 and #3) as evidenced below:

A. Timely monitoring and implementation of measures to minimize the frequency of emergency room visits for Resident #3 had not been provided timely.

Interview with the residential staff on 4/30/10 at 8:49 a.m. revealed that Resident #3 had been hospitalized several times since the 6/25/09 survey. Interview with the home manager on 4/30/10 at approximately 9:40 am. revealed that the practice was that if the resident did not have a bowel movement within 2 to 3 days, the nurse was informed so that the resident received his pm medication for constipation. The home manager also indicated that that if the resident did not have a stool in 3 to 4 day, upon assessment by the nurse and instructions by the physician, the resident was to be taken to the ER for assessment. Interview with the recently hired registered nurse (RN) on 5/3/10 at approximately 7:40 p.m., however revealed that she had not seen a written policy stating when the resident should be taken to ER for constipation.

Record review on 4/30/10 and on 5/3/10 confirmed the following ER visits/ hospitalization had occurred:

(1) A "Further Evaluation /Services Request" from Resident #3's day program dated 9/14/09 (12:30 p.m.) revealed he was evaluated for his complaint of abdominal pain, holding his

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I 401	Continued From page 11 abdomen tight and crying. Upon assessment the resident's abdomen appeared very hard and distended. The resident was reported as oriented x 3, to have faint bowel sounds, BP 156/96, T97 ,P76 R28. He appeared to be constipated - sat on the commode for a while, pushed and groaned, but could not go. Please treat accordingly and monitor closely. A reply note at the bottom of the form written by the GHMRP's RN, dated 9/14/09 (6:45 p.m.) revealed "Antacid given with relief. Laxative given 3 hours later. Fluids pushed. Vital signs were normal....Abdomen distended without complaint of pain during assessment. Ongoing assessment by staff. Review of an (UIR) dated 9/14/09 revealed at approximately 8:45 p.m., Resident #3 wes observed holding his stomach and complaining of pain. The supervisor was notified, and upon notification and instructions by the RN., the resident was escorted to the hospital ER for evaluation. A CT scan of the abdomen confirmed a small bowel obstruction. The medical impression was that it was most likely related to adhesions. The final diagnosis was "Small bowel obstruction, now resolved with conservative therapy." A low residue discharge diet was prescribed. The resident was discharged back to his group home on 9/24/09 (2) The review of an UIR dated 12/8/09 on 4/30,10 at 8:30 p.m. revealed that on 12/7/09, a direct care staff (DCS) informed the nurse that Resident #3 had not had a bowel movement since 12/4/09. On the next day (12/8/09) at approximately at 4:00 p.m., the LPN contacted	I 401		

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the staff and stated that per the RN coordinator's instructions, the resident should be taken to the ER, if he did not have a BM. Upon review of the resident's record, it was was determined by the LPN an the Qualified Mental Retardation Professional (QMRP) that the resident should be taken to the ER for evaluation.

On 4/30/10 at approximately 7:10 p.m., review of Residents #3's 12/9/09 ER discharge instructions revealed a primary diagnosis of pain-abdominal, generalized and a secondary diagnosis of Constipation - unspecified. Blood work, and an acute abdomen series and a CT of abdomen and pelvis w/ contrast were performed stat due to the resident complaint of abdominal pain. The resident was discharged from the ER in satisfactory condition with a recommendation for follow-up by the primary care physician (PCP) in 1 - 2 days, without fail.

(3) On 4/30/10 at 10:37 a.m., the review of an unusual incident report (UIR) dated 4/5/10 revealed that at 9:15 p.m. a direct care staff (DCS) discovered Resident #3 on the floor holding his side crying, and saying "I need to go to the hospital". According to the UIR, the supervisor was informed of the resident's complaint, then telephoned the registered nurse. Further review of the UIR revealed the R.N. instructed staff to escort the resident to the hospital. The resident was diagnosed with and treated for constipation, and then released to the group home.

(4) On 4/30/10 at 4:45 p.m., the review of an UIR dated 4/6/10 revealed that at 10:30 p.m., a direct care staff observed Resident #3 standing at the main entrance of the facility. The UIR documented that the resident had vomited all

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over the area. The R.N. was notified immediately and instructed staff to take the resident back to the emergency room for further evaluation.

(5) On 4/30/10 at 10:35 a.m., very loud yelling was heard coming from the front of the GHMRP. The home manager went to check, and returned saying that Resident #3, was the individual yelling. The manager commented that something was wrong with him.. Upon attempting to determine the reason for the resident's yelling, the home manager discovered that the resident complained of stomach pain and said that he wanted to go to the hospital. By 10:42 a.m., the yelling had subsided, however, the resident continued to whine. At 10:45 a.m., the home manager was observed preparing to send the resident to the ER with a DCS.

Record review on 5/3/10 at 10:40 a.m. revealed Resident #3 was discharged from the ER on 5/1/09 and that his primary diagnosis was constipation.

B. The GHMRP's nursing staff failed to coordinate services with the primary care physician (PCP) and the gastroenterologist (GI) to determine the criteria for administering the prn medication to prevent Resident #3's constipation as evidenced below:

Interview with staff from the day, evening, and overnight shifts at various times on 4/30/10 and 5/3/10 revealed Resident #3 continued to difficulty with regular bowel movements. The staff indicated that they had been instructed to inform the nurse if the resident did not have a BM in two to three days. The staff also reported that the resident's stools were often large and hard stools. Review of the daily stool documentation

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I 401	Continued From page 14 on 5/3/10 at approximately 11:35 a.m., for the 4/2010 confirmed the staff statements. Interview with the recently hired RN on 5/3/10 at approximately 7:40 p.m., however revealed she was hired by the agency on 4/8/10. The RN acknowledged that there had been several changes in the RN coverage at the GHMRP. The RN revealed that her review of Resident #3's record failed to identify instructions or a protocol on when the resident was to be given the prn medications (Constulose or Milk of Magnesia) for constipation. On 4/30/10 at 6:40 p.m., review of an RN progress note dated 10/22/09 written to the gastroenterologist (GI) revealed, " He was last hospitalized on 9/14/09 for bowel obstruction. He has had problems with regular bowel movements. His diet was changed from high fiber to low residue. The docusate sodium does not appear to keep him regular. Is there another medication he can take? Fluid intake is good. Hospitalized for GI Distress 6/7/09 and 9/14/09. The GI responded by prescribing Lactulose 30 ml po prn constipation prn and to follow up in 2 months." On 4/30/10 at 6:55 p.m., review of a RN monthly progress summary dated 11/09 (for 10/09), indicated that the GI specialist had added a prn laxative to Resident #3's medication regimen. The staff are continually reeducated verbally regarding the need to follow closely. [The resident's] elimination pattern still erratic (every 3 days or 4 days), taking meds as directed. The nurse acknowledged the GI's order for Lactulose prn to assist in his GI issues.. and noted "Bowel movements noted every 3 - 4 days. Drs. are aware."	I 401		

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I 401	Continued From page 15 Continued record review on 5/3/10 at 11:07 a.m. revealed the monthly nursing summaries for 1/09 and 12/09 documented an erratic stool pattern, with Resident #3 having stools every three to four days. It should be noted that although nursing progress notes dated 1/18/10 documented that Resident #3 should receive the Constulose 30 ml daily pm, review of the medication administration records revealed that the resident had only received it during 12/09. At the time of the survey, there was no evidence nursing services had coordinated with the primary care physician and the gastrologist to obtain further instructions on when to administer the pm medication for constipation. [Note: Observation of the medication supply on 4/29/10 at 7:40 p.m. and again on 7:50 p.m., revealed no Constulose was available at the GHMRP.] II. The GHMRP failed to ensure timely medical follow-up for Resident #3 after his emergency room visits due to constipation, as evidenced below: A. On 4/30/10, at 10:37 a.m., the review of an unusual incident report (UIR) dated 4/5/10, revealed that at 9:15 p.m., a direct care staff (DCS) discovered Resident # 3 on the floor and crying. He was taken to the ER for evaluation and was diagnosed with "pain -abdominal" and "constipation -slow transit". The Resident returned to the emergency room on 4/6/10 for assessment of vomiting. Review of the ER discharge summary dated 4/6/10 for the 4/5/10 visit revealed "follow-up with the primary care	I 401		

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I 401	Continued From page 16 physician (PCP in two to four days" and to "contact the ER" if there was a problem arranging the follow visit with the PCP. A high fiber diet and more fluids were recommended. Record review on 4/30/10, at approximately 6:10 p.m., revealed a a consultation report from the primary care physician (PCP) dated 4/13/10, which stated that the resident was evaluated in the ER for constipation and that the symptoms were now resolved. There was no evidence that the resident receive follow-up within the recommended time frame. It should be noted that Resident #3's stool records revealed he continued to have hard stool every one to three days, between 4/13/10 and 4/24/10. Documentation of stools between 4/24/10 and 4/30/10, revealed no evidence that the resident had any stools for six days. Due to a complaint of abdominal pain, the resident returned to the ER on 4/30/10 and was diagnosed with constipation. B. The review of an UIR dated 12/8/09 at 8:30 p.m. revealed Resident #3 was evaluated at the ER on 12/8/09 for constipation. Review of Residents #3's 12/9/09 ER discharge instructions revealed a primary diagnosis of pain-abdominal, generalized and a secondary diagnosis of Constipation - unspecified. The discharge summary included a recommendation for follow-up by the primary care physician (PCP) in 1 - 2 days, without fail. The resident record failed to document evidence that the PCP follow-up until 12/14/09, five days after his readmission to the group home. III. The GHMRP's primary care physician (PCP) failed to ensure oversight of the medication and	I 401		

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I 401	Continued From page 17 diet prescribed for Resident #3 to prevent constipation as evidenced below: During the medication administration observations on 4/29/10, at 7:28 p.m., Resident #3 received Docusate sodium 50 mg/5 ml, 100 mg/10 ml by mouth. The review of the 4/1/10 physician's orders revealed the medication was prescribed as a stool softener. Further record review on 5/3/10 at 10:45 a.m., revealed a current physician's order for Constulose 10 gm/15 ml syrup, 30 ml by mouth daily, as needed for constipation. The physician's orders revealed that the Constulose was initially prescribed on 10/23/09 by the gastroenterologist and was subsequently approved by the PCP. Review of the medication administration for 10/2009 revealed a 10/23/2009 order for "Lactulose 30 ml po daily as need for constipation." On 5/3/10 at approximately 7:45 p.m., interview with the newly hired registered nurse (RN) revealed that it could not be ascertained if and when the resident may have received the Constulose other than in 12/09. Continued interview with the RN and the licensed practical nurse (LPN) revealed that no Constulose available at the GHMRP. On 5/3/10 at 10:35 a.m., the review of the medication administration record (MAR) for 11/09 revealed that MOM 1 oz. PO as needed in the evening was listed and not the Constulose. According to the 12/2009 MAR, the resident was administered Constulose in the evening on eleven days. Continued review of the MARs from 10/2009 through 5/3/10, however, revealed no documentation that Resident #3 was administered Constulose at any other time. It	I 401		

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I 401	Continued From page 18 should be noted that the MAR documented the administration of MOM on 10/11/09 (for hard stool) and 10/14/09 (for no stool reported by staff). At the time of the survey, there was evidence medical criteria had been established to determine when to administer the Constulose and/or the prn. Additionally, there was no evidence effective preventive measures had been implemented to minimize Resident #3's risk of constipation. IV. The GHMRP's nursing services failed to ensure lost/missing medication was documented as evidenced below: Observation of the medication administration on 4/29/10 at 7:35 p.m., revealed that Resident #1 received Dilantin 50 mg tab (3 tabs), 150 mgs. The nurse was observed to punch the pills from the section of the card dated 4/30/10. Interview with the nurse at the time the medication was punched from the card revealed he did not know the reason the evening dosage of the Dilantin for 4/29/10 was missing. Further interview with the both the R.N. and the medication nurse on 4/29/10 indicated that a dosage of the Dilantin was already missing from the card when they began working for the agency, approximately 10 days prior to the survey. According to the nurses, if a resident's medication was lost for any reason, it should be documented in the resident's record, then reordered from the pharmacy. V. The GHMRP failed to ensure medication was administered without error for Resident #1 as evidenced below:	I 401		

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I 401	Continued From page 19 On 4/29/10 at 7:36 p.m., the medication nurse was observed to apply Desonide Cream 0.05% cream to Resident #1's face. At 7:38 p.m., a direct care staff informed the resident that it was time to go to the store and they left the home. At 7:55 p.m., the resident was observed returning to the home with staff and his housemates. Interview with the medication nurse 4/29/10 at 7:36 p.m., indicated that the resident was to have the Desonide Cream applied to his face in the evening. Interview with the qualified mental retardation professional (QMRP) on 4/30/10 at approximately 7:40 p.m. , however revealed the resident takes a shower before going to bed. The review of the 4/10 physician's orders on 4/29/10 at approximately 7:50 p.m. revealed the resident was prescribed to have the medication applied to his face at bedtime. At the time of the survey, there was no evidence that the medication nurse ensured that Resident #1 medication was applied to his face in accordance with the physician's orders. VI. The GHMRP failed to ensure timely dental treatment services for Resident #3 to address his dental caries as evidenced below: Observation of Resident #3 on 4/29/10 at 7:22 p.m. revealed he had missing teeth. Interview with direct care staff on 5/3/10 at approximately 3:35 p.m. revealed Resident #3 required encouragement and assistance from staff to ensure thorough tooth brushing. Record review on 5/3/10 at 4:07 p.m. revealed	I 401		

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I 401	Continued From page 20 the following information regarding Resident #3's dental health during consultations: 10/1/09 - (Follow-up periodontal treatment) Diagnosis: Severe gingivitis, heavy plaque and calculus, generalized caries of teeth #'s 4, 12, and 15. Full mouth scaling performed. Recommendations: (1) Assistance with tooth brushing; (2) Periodontal maintenance in 2 months; (3) Caries to be addressed by general dentist. 11/23/09 - (Annual oral examination) Diagnosis: Large deposits of plaque and calculus is present on most teeth surfaces. Recommendation: Return to this office for full mouth scaling and prophylaxis. Request for preauthorization to be made, and once it is obtained by the dentist, dentist will call group home to reschedule resident's appointment. 2/3/10 - (Follow-up cleaning/extraction evaluation) Diagnosis: Gingivitis, heavy plaque and calculus, and generalized caries. Full mouth scaling performed. Recommendations: (1) Assistance with tooth brushing 3 x daily; (2) Periodontal maintenance in 2 months; (3) Generalized caries to be addressed by general dentist. 4/7/10 - (Follow-up periodontal treatment) Diagnosis: Generalized bleeding, improved hygiene, not as much plaque. Full mouth scaling performed. Recommendations: (1) Continue assistance with tooth brushing 3 x daily; (2) Periodontal maintenance in 2 months; (3) Needs appointment with general dentist for caries control. At the time of the survey, there was no evidence	I 401		

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I 401	Continued From page 21 that the time of the survey, there was no evidence that Resident #3's caries identified by the periodontist on 10/1/09 and been filled and/or addressed. VII. The GHMRP failed to ensure quarterly drug regimen reviews for were conducted timely for Resident #3, #4, and #5 as evidenced below: A. Observation of the medication administration pass on 4/29/10, at 6:19 p.m., revealed Resident #4 was administered Risperdal 3 mg and Geodon 20 mg. Record review on 4/30/2010 at 2:35 p.m. revealed the most recent drug regimen review on file for Resident #4 was signed and dated 1/6/2010. Considering this date, a follow-up review should have been completed no later than 4/6/2010. Interview with the GHMRP's Registered Nurse (RN) on the same day at 2:45 p.m. confirmed there was no other drug regimen review on file for the resident. B. Observation of the medication administration pass on 4/29/10, at 7:22 p.m., revealed Resident #3 was administered Lipitor 20 mg and Docusate Sodium 50 mg/5 ml, 10 mels 5 mg. Record review on 4/30/2010 at 6:45 p.m. revealed the most recent drug regimen review on file for Resident #3 was signed and dated 1/6/2010. Considering this date, a follow-up review should have been completed no later than 4/6/2010. Interview with the GHMRP's Registered Nurse (RN) on the same day at 2:45 p.m. confirmed there was no other drug regimen review on file for the resident. C. Observation of the medication administration pass on April 29, 2010, at 6:35 p.m., revealed Resident #5 was administered Tegretol 200 mg and Risperdal 0.5 mg by mouth. Record review	I 401		

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I 401	Continued From page 22 on 4/30/2010 at 2:05 p.m. revealed the most recent drug regimen review on file for Resident #5 was signed and dated 1/6/2010. Considering this date, a follow-up review should have been completed no later than 4/6/2010. Interview with the GHMRP's Registered Nurse (RN) on the same day at 2:45 p.m. confirmed there was no other drug regimen review on file for the resident. VIII. The GHMRP failed to ensure Resident #3's therapeutic diet was provided timely, as prescribed to address his health concern (constipation),as evidenced below: A. On 4/30/10 at 8:30 p.m. , the review of an (UIR) dated 9/14/09 revealed at approximately 8:45 p.m.,Resident #3 was admitted to the hospital with a diagnosis of small bowel obstruction. A low residue diet was prescribed at discharge and the resident was readmitted to his group home on 9/24/09. A registered nurse (RN) coordinator progress note dated 4/5/10 documented that the client would receive followup by the primary care physician and the nutritionist. Continued record review on 5/3/10 at approximately 4:00 p.m. revealed a "readmission nutrition report" was conducted on 10/12/09, two weeks after Resident #3's return to the home. The report acknowledged the resident's hospital diagnosis of constipation and recommended to discontinue previous diet and to provide a low residue diet with Ensure twice daily. It also noted that 8 glasses of water daily should be encouraged and recommended that a physical therapy consult be conducted for a possible exercise program. There was no evidence, however, that the nutritional assessment had	I 401		

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I 401	Continued From page 23 been conducted timely or assessed the feasibility of using foods to improve the resident's irregular bowel elimination. B. The review of an UIR dated 12/8/09 on 4/30/10 at 8:30 p.m. revealed Resident #3 was taken to the ER for an evaluation due to no bowel movements for several days. The 12/9/09 ER discharge instructions revealed a primary diagnosis of pain-abdominal, generalized and a secondary diagnosis of Constipation - unspecified. The aftercare instruction suggested not enough roughage or fiber and liquids in the diet as a possible cause of the constipation. Recommendations included a high fiber diet and 10 -12 cups of fluids daily. On 5/3/10 at approximately 4:10 p.m., review of the Annual Nutrition Note, dated 12/29/09 revealed the post hospital nutrition follow-up was conducted three weeks later. This assessment documented that the resident would benefit from a high fiber diet. It further included a recommendation to discontinue the low residue diet and to implement a high fiber diet. There was no evidence there the PCP had coordinated with nutritionist to ensure that the resident's constipation was addressed timely. C. The GHMRP failed to ensure that menus were adjusted to accommodate the high fiber diet recommended for Resident #3, as evidenced below: On 4/30/10 at 10:37 a.m., the review of an UIR dated 4/5/10 at 9:15 p.m. revealed Resident #3 was taken to the ER where he was diagnosed with, and treated for constipation. Continued review of the UIRs revealed on 4/6/10 at 10:30 p.m., he returned to the ER due to vomiting.	I 401		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0202	A. BUILDING _____ B. WING _____	05/03/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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I 401	Continued From page 24 On 5/3/10 at approximately 4:25 p.m., the review of the "nutrition assessment quarterly note" dated 4/13/10 revealed, "Individual continues to suffer from constipation. Diet appropriate to overall health. BUN slightly high. possible hydration issue. Will encourage fluids daily." At that time, a high fiber diet with prune juice twice daily was recommended. Continued record review on the same day at approximately 4:35 p.m. revealed Resident #3's "follow-up nutrition assessment" was dated 4/29/10. According to the assessment, the resident was "having difficulty swallowing regular consistency. Individual holds food in mouth, takes a very long time swallowing. Individual will be able to tolerate a mechanical soft diet. Will notify SLP (speech and language) for screening." Review of the menus on 4/30/10 at 9:30 a.m. revealed a single menu for all residents. Interview with the nutritionist on 4/30/10 at 10:39 a.m. revealed that the menus were "Heart Healthy" and should be appropriate for all residents in the GHMRP. Interview with staff on 5/3/10 at 4:40 p.m. revealed that the resident's food was cut to bite size and that he could chew it finely, but that it took him a long time. On 5/3/10 at 5:05 p.m., review of menus available at the group home for 4/2010 and 5/2010 revealed they failed to provide specific guidelines for staff on how to prepare a mechanically soft high fiber diet. [Note: Resident #3 returned to the ER on 4/30/10. The discharge summary dated 5/1/10, revealed that he was again diagnosed with constipation.]	I 401		

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I 407	Continued From page 25	I 407		
I 407	3520.9 PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall obtain from each professional service provider a written report at least quarterly for services provided during the preceding quarter. This Statute is not met as evidenced by: Based on record review and staff interview, the GHMRP failed to ensure quarterly nursing reviews and assessments were completed on a timely basis to maintain a resident's health and safety. [Residents #3, #4, and #5] The findings include: 1. Record review on 4/30/10 at 6:35 p.m., revealed the most recent nursing quarterly on file for Resident #3 was signed and dated 12/2009. Interview with the GHMRP's registered nurse (RN) on the same day at approximately 7:15 p.m., confirmed no quarterly assessment was completed for the resident after 12/2009. Resident #4's last monthly nursing assessment was also dated 12/09. The record documented nursing progress notes every one to two weeks thereafter, until 4/10/10. The progress notes, however, failed to closely monitor the status of the resident's most pressing medical concern which was constipation. At the time of the survey, the GHMRP failed to ensure the timely completion of nursing quarterly assessments to ensure Resident #3's health and safety. 2. Record review on 4/30/10 at 2:08 p.m. revealed the most recent nursing quarterly on file	I 407	See W336	

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I 407	Continued From page 26 for Resident #4 was signed and dated 9/2009. Interview with the GHMRP's RN on the same day at approximately 2:50 p.m. confirmed there was no other quarterly assessment completed since 9/2009. In addition, she explained that whatever was in Resident #4's medical record was all that was available to review. The GHMRP failed to ensure the timely completion of nursing quarterly assessments to ensure Resident #4's health and safety. 3. On 4/30/10, at 1:42 p.m., review of the Resident #5's medical record revealed the most recent nursing quarterly on file was signed and dated 9/2009. Interview with the GHMRP's registered nurse (RN) on the same day at approximately 2:50 p.m., confirmed there was no other quarterly assessment completed since 9/2009. In addition, she explained that whatever was in Resident #5's medical record was all that was available to review.	I 407		